

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.

Drug Requested: Xyrem® (sodium oxybate)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

- To guard against diversion and misuse, the drug's distribution is limited and prescribers must adhere to a risk management protocol, the Xyrem® REMS Program.

CLINICAL CRITERIA: Check below **ALL** that apply. Boxes **must** be checked to qualify or authorization process will be delayed. Chart notes and lab results **MUST** be attached to this request.

- Patient is at least 16 years old
 - Patient **is NOT** receiving treatment with sedative hypnotics, other CNS depressants (*verified by paid pharmacy claims*)
 - Patient **is NOT** using alcohol
 - Patient **does NOT** have a history of drug abuse
- AND**
- Patient has a diagnosis of narcolepsy with cataplexy (*MSLT confirming diagnosis of narcolepsy and chart notes documenting cataplexy symptoms must be submitted*)
- OR**
- Patient has a diagnosis of **excessive daytime sleepiness associated with narcolepsy AND** has failed a 30-day trial of modafanil or armodafinil (*Polysomnography and MSLT confirming diagnosis of narcolepsy must be submitted*)

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

*Approved by Pharmacy and Therapeutics Committee: 10/18/2012
REVISED/UPDATED: 3/12/2014; 11/6/2014; 5/22/2015; 12/22/2015; 5/6/2016; 5/12/2016; 6/23/2016; 12/20/2016; 8/21/2017.